Compulsive Behaviors in area of Kedusha

Educators Event

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JNARS, or Jewish Network of Addiction Recovery Support, is a registered non-profit organization dedicated to improving recovery from addiction in the Jewish world.

The JNARS Professional Network is currently the biggest platform for Addiction Specialists serving the Jewish community to work together to help solve the problem of addiction in our communities, with over 250 members.

- Shlavim is a therapy referral and case management service for the English speaking population in Israel, providing support for individuals and couples suffering from abuse, neglect, addiction, and other mental health challenges.

- Our goal is to match an individual with the best possible therapist for their situation and to help each client navigate the therapy process along the road to success.

- Shlavim is a non-profit, privately funded organization, receiving no fee for any of its services.

- For more information, please contact:

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SHLAVIM

Goals

For Educators to be able to-

1) Differentiate compulsive behavior (serious) suggesting professional intervention from a subclinical (not as serious) issue

2) Identify a great variety of behaviors in which this problem can appear or manifest

3) Understand what treatment may look like

4) Know which resources exist to help our talmidim with this problem

Which one is it?

רעואל

יתר

יתרו

חובב

חבר

קיני

פוטיאל

In the Professional Literature this issue is uniquely problematic to study as it is given so many different names-

1 Sexual Addiction (Carnes & Goodman; ASAM & NIDA; DSM 3-R)
2 Sexual Impulsivity (Barth & Kinder)
3 Compulsive Sexual Behavior (Coleman & Quadland)
4 Impulsive-Compulsive Sexual Behavior (Coleman)
5 Obsessive-Compulsive Sexual Spectrum Disorder
6 Hypersexuality (Kafka & Stein)
7 Problematic Hypersexuality
8 Dysregulated Sexuality (Winters & Gorzalka)
9 Sexual Behavior that is out of Control (Bancroft & Vukadinovic)
10 Sexual Disorder Not Otherwise Specified (DSM 4 & 5)
11 Satyriasis & Nymphomania (ICD-10)

Professional Debates Abound……

1 Debate One

Primary Disorder, Symptom of Diagnosable Disorder, or Subclinical Problem?

2 Debate Two

It's a disorder in it's own right-but which one?

3 Debate Three

If these behaviors can be characterized as addiction, where do we draw the line- e.g. is cutting/exercise an addiction?

Screening for This Addiction

Start Here:

[duration of 12 months, at least four criteria, etc.]/Criteria borrowed from DSM for Drug Addiction:

A) **Loss of Control** *(regardless of patient morals, culture, etc.)*?

- Loss of control as defined by: The behavior is often engaged in over a **longer period**, in **greater quantity**, or **at a higher level of intensity than was intended**

- **Efforts to cut down** or control the behavior have repeatedly been **unsuccessful**

B) **Continuation Despite Adverse Consequences**?

- The behavior continues despite persistent or recurrent **social** or interpersonal problems that its effects have caused or exacerbated

- The behavior continues despite knowledge of having a persistent or recurrent **physical** or **psychological** problem that is likely to have been caused or exacerbated by the behavior

- The behavior is recurrently performed in **situations** in which doing so is physically **hazardous**

Example of consequences:

- Talmid has already been warned by Yeshiva to improve his performance or attendance or be forced to leave
- Talmid never gets sleep and consequently gets sick often
- Talmid has very significant anxiety and depression after doing this, hates himself

Examples of "efforts to cut down" that were unsuccessful (usually several of these together):

Put tefillin under pillow but still did it
Slept with Sefer in bed but still did it
Made an oath that will never do so again but broke it
Gave himself a hefty k'nas each time he did it but still continued
Tried fasting/going in (sometimes) freezing mikva to stop but still continued
Wrote a contract with Hashem but still continued
Cried and begged Hashem to help him stop more than once but continued
Added extra learning until so busy he had no time to do it but still continued
Felt significantly depressed by this whole thing but then went and did it again

***Don't* Start Here:**

a) Culturally Unacceptable Behaviors

b) Lots of the behavior (quantity per day etc.)

c) Client feels guilty

Point: Although something can be an aveirah & forbidden/foolish to do/morally unacceptable etc. this criteria alone doesn't make something an addiction. An addiction is a chronic brain disorder featured mainly by a loss of control and continuation despite grave consequences.

Screening for this Addiction

Once you have together established both
a) loss of control and
b) continuation despite adverse consequences,

then continue here:

● Important social, occupational, or recreational activities are **given up or reduced** as a result of engaging in the sexual behavior

● Continuation engaging in the sexual behavior has resulted in failure to fulfill significant **responsibilities** at work, school, or home

● A **great deal of time is spent** in activities necessary to prepare for the sexual behavior, engage in the behavior**, or recover from its effects**
● The subject experiences a **craving** (strong desire or urge) to engage in the behavior

● **Tolerance**-*a)* needing more frequency & intensity to achieve desired effect; or *b)* same frequency & intensity of behaviors no longer produces desired effect

● **Withdrawal**, as manifested by either *a)* a characteristic biopsychological withdrawal syndrome of physiologically described changes and/or psychologically described changes upon discontinuation of the sexual behavior; or *(b)* the same (or a closely related) sexual behavior is engaged in to relieve or avoid withdrawal symptoms

Extra suggested criteria to further assist in discrimination, borrowed from criteria for DSM's gambling disorder:

- Mental **Preoccupation**,
- Engaging in the behavior **to relieve** dysphoric moods, restlessness or irritability
- **Lying to conceal the extent** of the behavior

(Goodman, 2015)

Addiction described as having three severity levels-

- Mild
- Moderate
- Severe

NOT EVERYONE IS IN ONE BOX!!!

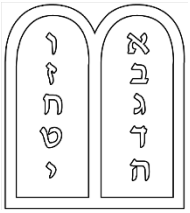
((**Addiction-Levels of severity in DSM 5**

"Substance use disorders occur in a broad range of severity, from mild to [moderate to] severe, with severity based on the number of symptom criteria endorsed.

As a general estimate of severity, a *mild substance use disorder is suggested by the presence of two to three symptoms, moderate by four to five symptoms, and severe by six or more symptoms.*

Changing severity across time is also reflected by reductions or increases in the frequency and/or dose of substance use."))

Which criteria is **NOT** classified as an Addiction by itself with no other signs?



a) Immoral Activity

b) Culturally-unacceptable or illegal activity

c) Fetishistic behaviors that are **1)** in control and **2)** don't bear significantly harmful consequences to self or others

d) SSA attractions and even behaviors

e) Someone who has done the behavior many times a week or per day, even 5 TSO per day

f) Watching hours of pornography in a row with tremendous guilt and shame

g) Having affairs etc. without a loss of control and without significantly harmful consequences

Paraphilias are not “Addiction”; S- Offending is also not “Addiction”. However, comorbidity may exist with both Paraphilia and this Addiction, just like any other two diagnoses.

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Voyeurism
Exhibitionism
Frotteuristism
S- Masochism (being beaten, Asphyxiophilia)
S- Sadism (beating others for arousal)
Pedophilic Disorder (young boys/girls)
Fetishistism (focus on nongenital body parts, non-living objects for arousal)
Transvestism (clothes, “Autogynephilia”)
Other Specified Paraphilia (Telephone Scatagolia, Zoophilia, Coprophilia, Necrophilia)

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Paraphilic Disorders are closely related to this Addiction, like cousins who are also best friends. They are not the same, but often coincide together within such an addiction.

Paraphilia, Attraction Orientation, & Addiction Overlap

Addiction involves mental cues and memory. “Triggers” are central in addiction, and are basically people-places-things that are cues which arouse the addictive system.

If the arousal template has incorporated a paraphilia within an addicted person, then this interest may become a trigger or cue to set off the addictive cycle.

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Similarly, a person addicted to this who also has SSA will naturally be aroused by “attractive” men, which can set off an urge to act on his addiction-behaviors.

Differential Diagnosis

"Obsessions and compulsions with such content can occur in OCD… …However, the content of these obsessions consisted most often not of fantasies but of fears of acting on sexual impulses or fears of being a pervert.

…As noted earlier, the symptoms of sex addiction differ from obsessions and compulsions primarily in that the former are associated with **arousal and pleasure** while the latter are typically accompanied not by arousal but by **anxiety**."

Some Helpful Assessment Questions

What exactly do you struggle with?-
-Acting out with people?
-Things on the internet?
-Are objects involved?
What exactly is it that you do? Can you describe more so I understand better
What types of things do you watch?
How often does this occur?
What makes it worse?
What makes it better?
What are the conditions that, when you have them, you don't even think of doing this?
Have you ever tried to stop before? How?
Are there certain thoughts/emotions/physical feelings that precede and encourage you to do this?
How long have you had this problem?
Did the problem get worse over the years?
What is the longest time that you've been free from doing this?
When exactly is the last time that you did this?
Do you have a theory about why exactly you do this?
Are there things in your environment or possession that make this harder or give you access to what you do?
What triggers you? Which people/situations/emotions/opportunities/ feelings/ etc.?
Do you have urges? Are they painful? What is that like? Is it sudden? How they work?

Continuation of possible questions-

Do you have other struggles as well like with anxiety? Depression?
Were you abused in any way or traumatized?
Are things okay back at home?
Do you have any friends? Close friends that you share things with?
What resources do you have to get better? $$$? Willingness?
etc. etc. etc. …….

Now review in your mind what you heard and ask yourself-

Do you think this is a problem that you or the Yeshiva has the tools to solve?
Is the problem caused by a lack of information, which by giving over this information the problem will be solved?
Is the problem one that may suggest a mental health professional's outlook & assistance?
Do you see a problem that can be easily solvable by treating the environment or access to internet, etc.?
Do you see several problems that interact with one another or need attention?
Etc. etc. etc.

BY NOW YOU SHOULD HAVE SOME SORT OF DIRECTION

Despair=Must Address

Particularly with frum people, despair is a feature that, if not worked through, can become a barrier to treatment.

Common despair themes:

"The Zohar says there is no way to do teshuva"

"I've done this so many times, there is no way Hashem will help me anymore"

"I don't really think it is possible to stop, I've already tried for years"

The Onion model

The Problem

Environment

Intrapsychic (In the mind)

- Addiction itself
- Other issues that interact with addiction

Which are the outer layers that need peeling or attention first?
If I deal with the outer layers first will that solve other inner layers or problems?
What resources are available to help the talmid? Who can connect him to these resources?

Addiction is Chronic

Chronic=Something that won't completely go away with treatment, requires ongoing maintenance/effort to keep up the status quo.
Example: Like Diabetes-doesn't go away but can be managed.

Clarification: People get better!

However, the unique "allergic" or irrational relationship always remains in the way that, if a person isn't careful, he can relapse. This is unlike a virus that comes and goes, or like a broken leg.

Measuring Recovery

Recovery from addiction includes-

1 The behavior stops being performed because of growth and working on self, not simply "by force" & mere willpower. Involves stopping for significant amount of time, or there is a measurable and significant reduction in use and/or consequences that were caused by the addiction-behavior.

2 Growing in various domains (socially, productivity, spiritually, psychological health, physical health, lifestyle balance, maturity, interpersonally, etc.)

Defining Slip, Lapse, Relapse

Learning to ride a bike-

- Takes time
- Can fall off while learning
- Never throws himself off on purpose so don't do that either

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- Differentiate high risk from low risk situations

Cliff Model

IDEA: Build a repertoire of tools that will keep talmid away from the cliff edge

Three categories of tools-

-Tools that one days everyday to maintain status quo and life balance

-Tools for when a person starts walking towards the edge, to return to safety

-Tools for the extreme situation in which one is on the actual cliff edge

Status Quo	>>>>>>>>>>> Person moving towards edge	Cliff Edge!!!

SFT

Solution-Focused Therapy

A very brief intervention to help people identify inner-resources and strategies to work through their problem. Very external model, but helpful, especially with limited time.

MI

Motivational Interviewing

A style of therapy used to help people with no motivation to stop or change

Mindfulness/Urge-Surfing

Acceptance & Commitment Therapy/MBRP

A set of tools that seeks to change not the content of one's thoughts, & not to reduce one's pain. Rather, it teaches the person to relate to thoughts and feelings in a new way. It tackles process, not content. If the addicted person can take his thoughts less seriously, learn to feel his urges or anxiety without reacting as much….he will no longer be prompted by them to use.

CBT

Cognitive Behavioral Therapy

3rd Wave CBT, is a structured type of therapy that identifies particularly problematic thoughts, emotions, and teaches skills used to give a new contextual relationship to these difficulty-areas.

12 Steps

A spiritual Mutual Aid program using 12 spiritual principles to get a “daily reprieve” from the “allergy of addiction”.

GYE

https://guardyoureyes.com/

Online Forum of frum people on many different levels, struggling in these areas. The GYE community has many tools available to people online, by phone, reading material or audio, and other resources. The forum is run by people who have struggled in the past and successfully broken free of these behaviors via 12 steps and other methods.

Inpatient
Intensive Outpatient
Individual
Mutual Aid
Support Group

Treating the environment=Internet Filters

Recovery Capital

The idea that the more resources one has, the more "capital" one has to successfully recover.

Example: An unemployed person can gain more "recovery capital" by finding a job. The job can help a person recover **indirectly**, by empowering the person, helping them become more dependent and feel a sense of responsibility, make money needed to get therapy, feel good about one's self, create a positive social network, and more.

The more things one has going for him in life, the better his chance of recovery.

Lesson: Even things that seem to be indirectly related to addiction treatment can have great benefit in helping to recover.